What do the reforms in the Affordable Care Act (ACA) mean for 50- to 64-year-olds? Much depends on whether they have health coverage now and on how they get it. Most people in this age group are covered through employers, so employers’ decisions about health benefits shape their options. For those who have modest incomes and who currently buy coverage in the individual market, the reforms may help make coverage more affordable and remove obstacles for anyone with health problems. For those who are uninsured now, ACA improves access to private and public coverage and offers financial help for people with low incomes.

Nearly 61 million people, 20 percent of the U.S. population, were ages 50 through 64 in 2012. Almost 52 million (85 percent) had health insurance coverage, mostly through an employer’s health benefit plan. The remaining 9 million adults in this age group lacked coverage (figure 1).

This “Insight on the Issues” explores what reforms within the Affordable Care Act (ACA) may mean for different segments of this population.

The paper looks at the effect the law may have for adults with employer coverage. It also explores the effect on two alternate sources of coverage: the private individual health insurance market and Medicaid. Each currently covers a small share of the population ages 50 through 64, but, under ACA, they are the centerpieces for expanding health insurance to those who are uninsured or underinsured.

The paper discusses how creation of Health Insurance Marketplaces (Marketplaces), how subsidies offered through them, and how the Medicaid expansion program could improve access to health coverage, make it more affordable for some, and reduce the number of uninsured older adults.

Employer Coverage Is the Mainstay for Older Workers and Their Families

Three-quarters of the 52 million insured adults ages 50 through 64 (39 million adults) had employer coverage in 2012, by far the most prevalent source of coverage for this age group (figure 1). Most receive coverage from their own employer, but many get coverage through a family member’s employer plan. Of the 39 million covered by an employer plan, 10 million (or 26 percent) were dependents on a family member’s plan.

Table 1 shows who among people ages 50 through 64 are most likely to have employer-sponsored health insurance coverage. Specifically, it shows the following:
Work status and employer size affect the likelihood of having health insurance through an employer.

- Full-time, full-year workers are more likely to have employer coverage than those working part-time or part of the year.
- Employees working for large employers (100+ employees) are more likely to have employer coverage than those working for small employers (< 50 employees).
- About one-half of self-employed older adults had employer-sponsored coverage—many as dependents on a family member’s employer plan.
- About one-third of nonworking older adults had coverage through an employer—many as dependents on a family member’s plan, others likely through COBRA continuation coverage or early retiree health benefits.

Racial and ethnic minority groups were 10 to 22 percentage points less likely to have employer coverage than whites were.

Some Workers Ages 50 through 64 Have No Employer Coverage

Although employer coverage is the most prevalent source of such coverage for workers, a striking number of workers are not covered through their employer (table 2). Almost 11 million people ages 50 through 64 who worked in 2012 did not have employer health insurance coverage. Among workers not covered by an employer in 2012, the following was found:

- More than one-half were uninsured.
- More than one-quarter bought private insurance on their own in the individual market.
- Ten percent had Medicaid coverage.

Figure 1. Adults with Coverage Depend Heavily on Employer Coverage, 2012

Table 1. Characteristics of 50- to 64-Year-Olds with Employer Coverage in 2012

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>% Covered</th>
<th>Number (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 50- to 64-year-olds</td>
<td>64</td>
<td>39.0</td>
</tr>
<tr>
<td>All 50- to 64-year-old workers (includes self-employed)</td>
<td>75</td>
<td>33.0</td>
</tr>
<tr>
<td>All 50- to 64-year-old nonworkers</td>
<td>36</td>
<td>6.0</td>
</tr>
<tr>
<td>50- to 64-year-old workers by work status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Among full-time, full-year workers</td>
<td>81</td>
<td>26.0</td>
</tr>
<tr>
<td>Among part-time, part-year workers</td>
<td>59</td>
<td>7.0</td>
</tr>
<tr>
<td>50- to 64-year-old workers by firm size</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work for large employer (100+ employees)</td>
<td>87</td>
<td>22.0</td>
</tr>
<tr>
<td>Work for small employer (&lt; 50 employees)</td>
<td>61</td>
<td>6.0</td>
</tr>
<tr>
<td>All 50- to 64-year-old self-employed workers</td>
<td>48</td>
<td>2.7</td>
</tr>
<tr>
<td>By race/ethnicity among all 50- to 64-year-olds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>52</td>
<td>3.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>47</td>
<td>3.0</td>
</tr>
<tr>
<td>White</td>
<td>69</td>
<td>30.1</td>
</tr>
<tr>
<td>Other/Mixed</td>
<td>59</td>
<td>2.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage in Own Name or as Dependent</th>
<th>Own</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among all 50- to 64-year-olds (%)</td>
<td>74</td>
<td>26</td>
</tr>
<tr>
<td>Number (millions)</td>
<td>29</td>
<td>10</td>
</tr>
<tr>
<td>Among self-employed (%)</td>
<td>47</td>
<td>53</td>
</tr>
<tr>
<td>Number (millions)</td>
<td>1.3</td>
<td>1.4</td>
</tr>
<tr>
<td>Among nonworkers (%)</td>
<td>43</td>
<td>57</td>
</tr>
<tr>
<td>Number (millions)</td>
<td>2.7</td>
<td>3.6</td>
</tr>
</tbody>
</table>


Table 2. Older Workers without Employer Coverage Are Most Likely to Be Uninsured, 2012

<table>
<thead>
<tr>
<th>Coverage status</th>
<th>%</th>
<th>Number (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 50- to 64-year-old workers not covered by employer plan</td>
<td>25</td>
<td>10.8</td>
</tr>
<tr>
<td>Uninsured</td>
<td>55</td>
<td>5.9</td>
</tr>
<tr>
<td>Other private</td>
<td>28</td>
<td>3.0</td>
</tr>
<tr>
<td>Medicaid</td>
<td>10</td>
<td>1.1</td>
</tr>
<tr>
<td>Other public</td>
<td>8</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Smaller percentages had Medicare or coverage through other public programs such as the Department of Veterans Affairs (VA).

ACA Encourages Employer-Based Coverage

One of the major goals of ACA is to reduce the number of uninsured people by improving their access to employer coverage, as well as to other private and public coverage options.

ACA has several provisions that encourage employers to offer—and employees to take up—employee health insurance, such as these:

1. To encourage large employers (defined as having 50 or more full-time employees) to continue to provide health insurance to workers, ACA includes a shared responsibility requirement. Under this requirement, large employers may face a tax penalty under the following conditions:
   - If they do not offer health benefits to full-time employees
   - If they offer health benefits that do not meet minimum value standards specified by the health law
   - If they offer health benefits that are not affordable
   - If one of their full-time employees buys coverage through the Marketplace and receives a public subsidy

2. To encourage small employers (generally 50 or fewer employees in 2014 and up to 100 employees in 2016) to offer health insurance, ACA created the following:
   - The Small Business Health Options Program (SHOP), which will increase the purchasing power of small employers and give them the option of offering multiple health plans to their workers
   - A small business tax credit for health insurance expenses for small employers with low-wage workers who are buying coverage through the SHOP

3. To prevent an exodus of workers from their employer’s plan, workers are eligible for subsidies in the Marketplace only if their employer’s coverage does not meet a minimum value standard or is not affordable.

4. To encourage workers to take advantage of coverage offered at work, ACA contains the following provisions:
   - Employers will automatically enroll new employees and automatically renew current enrollees in the employer’s plan.
   - Employees will be able to opt out of the coverage they were automatically enrolled in.
   - Individuals will be required to maintain minimum health coverage, either from an employer or another source, or will be subject to a penalty.

The Law May Affect Some Employer Coverage

It is too early to determine either how (much less the extent to which) employers will respond to the health law’s requirements or what the implications are for employer-based coverage and for older workers. A few studies and some policy experts have suggested that the incentives in the law may simultaneously encourage and discourage employers from offering insurance.

One study estimated that health insurance coverage among workers in small businesses may increase. The
study asserts that the tax credit will prompt some small employers—those who have fewer than 25 employees and who are not subject to the shared responsibility payment—to offer coverage. This tax credit could increase small employers’ coverage of employees from 30.5 million to 30.8 million.\textsuperscript{11}

The study estimated that—although the share of employees of small firms with employer coverage will not grow substantially—the share of uninsured workers will drop significantly because they will be able to get insurance either through the Marketplace or through the Medicaid expansion. Some workers who are buying Marketplace coverage for themselves and their families may also receive substantial subsidies if they have low incomes.

Not all assessments of the health law’s effects are positive, however. Some policy analysts have noted that the availability of Marketplaces and subsidies may lead some employers, especially those with low-wage workers, to discontinue offering coverage. Such a decision may be motivated by cost considerations because the penalty incurred for not offering health insurance coverage may be less than the cost of the benefit. In reality, such a decision may help the employee because some workers may find lower-cost coverage in the Marketplace (particularly if they qualify for subsidies).

Some stakeholders have also expressed concerns about unintended consequences. One concern is that employers—particularly small employers—will cease to hire additional full-time workers so they can keep their full-time employee count below 50 and can avoid the shared responsibility requirement. Another concern is that employers may reduce workers’ hours to part-time status to avoid providing coverage.

Whereas those and other actions may erode employer coverage to some extent, policy analysts generally expect that there may be limited changes to employer-based coverage overall. Most employees who have employer coverage will likely continue to receive their coverage through the workplace.

**Coverage Can Be through Other Health Insurance Sources**

Nearly 13 million individuals rely on health insurance that is not employer based. They may buy health insurance through the individual market or may rely on government-sponsored health programs.

Those individuals may or may not be working. Nonworkers include retirees; people who have left the workforce because they are sick, are disabled, or are taking care of a family member; and people who are unemployed or between jobs.

As shown in figure 1, in 2012 one in four insured adults ages 50 through 64 were covered through the private individual market or a government program such as Medicare, Medicaid, VA, and TRICARE (the latter two for the military).

Among those insured adults,

- More than 4.6 million purchased coverage through the individual market.
- Another 4.7 million received coverage through Medicaid.

**ACA Improves Access for Those Buying Insurance in the Individual Market**

Before ACA, adults who were in their fifties and early sixties and who sought coverage from the individual market often faced obstacles to obtaining high-quality, affordable health insurance. In 2010, ACA ended the practice that
allowed health insurers to drop coverage of those who became sick.

In 2014, additional changes will take effect:

- Health insurers can no longer refuse to cover people with existing health problems.
- They cannot charge higher premiums on the basis of health status.

Moreover, insurers face restrictions on how they set health insurance premiums. Premiums can vary only according to family size, where someone lives, age of the covered person at enrollment, and tobacco use. The law places additional restrictions on the extent to which insurers may vary premiums by age. Insurers can charge older adults no more than three times what they can charge younger adults. Previously, older adults often had to pay much higher rates than younger adults did.

When fully implemented, ACA is expected to make it easier for people to shop for coverage. In every state, new Health Insurance Marketplaces will be available from which individuals will be able to compare plans, premiums, and available subsidies.

All new plans sold in the individual market (whether through the Marketplaces or not) must meet the following requirements:

- Offer a common set of comprehensive benefits.
- Have no cap on the dollar amount to be paid for benefits annually or over a lifetime.
- Show the value of the plan by category (bronze, silver, gold, or platinum).

Although plans in all categories cover the same set of essential health benefits, they vary by how much enrollees are required to cover out of pocket for services used (that is, cost-sharing) and what the plan’s monthly premium is. Plans with higher cost-sharing requirements have lower premiums. Compared to a platinum plan, a bronze plan will have the lowest premium but the highest cost-sharing requirement.

To ensure that the insurance market can cover the risk of enrolling people with health problems, ACA requires everyone to purchase health insurance coverage, unless an individual qualifies for an exemption. Those who do not purchase insurance will face a penalty, which will phase in over three years. In 2014, the penalty is the higher of $95 or 1.0 percent of taxable income; in 2016, the penalty grows to $695 or 2.5 percent of taxable income.

**ACA Makes Coverage in the Individual Market More Affordable**

To improve access to coverage in the individual market, ACA also provides financial assistance on a sliding scale to individuals with low and modest incomes. The law creates two types of financial assistance:

- Tax credits to reduce the premium cost for individuals with household incomes between 100 percent and 400 percent of the federal poverty level
- Additional subsidies to reduce cost-sharing for individuals with household income under 250 percent of the federal poverty level

Unlike the employer market where employers’ contributions reduce the cost of coverage to employees, people buying in the individual market foot the total cost of coverage on their own. In instances where costs may be a barrier to buying health insurance, the availability
of subsidies may make buying coverage in the individual market more feasible.

One study illustrates the effect that subsidies will have on the cost of coverage. A hypothetical 60-year-old woman living in Los Angeles with an income of about $28,750 (250 percent of poverty) might pay a $541 monthly premium for a silver plan through the Marketplace. If she lived instead in Indianapolis, she might pay $626 for the same plan. With the subsidies, the study showed that this woman would actually pay $193 in both Los Angeles and Indianapolis.

As noted earlier, subsidies will be available to individuals with incomes between 100 percent and 400 percent of the federal poverty level. A significant number of older adults who either purchase insurance in the individual market or are uninsured will fall into that income group (figure 2). According to 2012 data,

- About 2 million (45 percent) adults ages 50 through 64 who bought health insurance in the individual market had incomes in the range that makes them eligible for subsidies.
- More than 5 million adults ages 50 through 64 (56 percent) who were uninsured had incomes in that range.

Some individuals in this market may have to find new health insurance plans starting in 2014. Individuals affected would include those who cannot renew their current plan because it does not...
meet the new standards. However, overall, the new market rules combined with the availability of financial assistance will provide a level of security not previously available in the individual market.

**ACA Creates a Path to Medicaid Coverage for Poor Adults**

Before ACA, poor and childless older adults without private health insurance generally did not have access to Medicaid coverage—unless they qualified because of a disability.

Beginning in 2014, older adults with income below 138 percent of poverty are technically eligible for Medicaid coverage if they meet income standards. Whether or not they receive coverage will depend on whether the state in which they reside extends that coverage.

ACA gives states the option to expand their Medicaid program to cover individuals under age 65 with income at or below 138 percent of the federal poverty level.

As of December 2013, 25 states and the District of Columbia were moving ahead to extend Medicaid coverage to poor adults, 2 states were trying to expand Medicaid after 2014, and 23 states were not expanding their Medicaid program.

If a state does not exercise the option to expand its Medicaid program, older adults in that state with income between 100 percent and 138 percent of the federal poverty level will have the option of buying subsidized private coverage in the Marketplace.

However, those with incomes below 100 percent of poverty will not have that option. Unless other public options are available to those individuals, they will not benefit from the new coverage options made available through ACA.

Among the 9 million 50- to 64-year-olds who were uninsured (figure 2) in 2012, the following was found:

- More than one in three had incomes under 139 percent of poverty and might be eligible for coverage under the Medicaid expansion if all states elected the option to expand.
- One in four—about 2.3 million—had incomes below 100 percent of poverty. Individuals in that group would be without new coverage options if their state does not expand Medicaid.
- Roughly 1 in 10, or about 1 million, had incomes between 100 percent and 138 percent of poverty. Individuals in this income group could access the Marketplace subsidies if their state does not expand Medicaid, although premiums might be a stretch for some—even with the subsidies.

In addition, one in five adults who bought insurance in the individual market in 2012 had incomes that could qualify them for coverage under the Medicaid expansion.

**Who Benefits from Expanded Access to Medicaid and the Individual Market?**

Because adults become more vulnerable to health problems with age, having access to coverage and care is important. This need is particularly urgent for low-income adults in their fifties and early sixties who, until now, may have been unable to either qualify for Medicaid or afford private coverage.

Getting those older adults covered will give them improved access to lifesaving preventive screenings and services without cost-sharing (e.g., colorectal cancer screening, mammograms, and immunizations). And when illness strikes, the coverage will allow them access to needed care.
For those who have struggled to buy coverage in the individual market or have gone without coverage, the new options offer more health security and financial protection in the face of serious illness.\(^{21}\)

By improving access to care, expanding Medicaid to poor uninsured older adults might reduce racial and ethnic disparities in coverage. Older adults in racial and ethnic minority groups are uninsured at higher rates and are disproportionately more likely to have low incomes. In 2012, the following was found for those adults:

- African Americans were 8 percentage points less likely to have health insurance than were whites.
- Hispanics were 19 percentage points less likely to have health insurance than were whites.

One study estimates that the combination of Medicaid expansion and premium tax credits available to people through the Marketplace could significantly reduce disparities.\(^{22}\)

**Implementation May Face Challenges**

As access to the new coverage options begins in 2014, adults in their fifties and early sixties, as well as other age groups, have a lot to gain from successful implementation of ACA.

Attention to a number of factors will be critical to ensure that individuals are able (a) to enroll in the plan or program of their choice, (b) to receive the subsidies for which they are eligible, and (c) to have access to services. These factors require the following:

- Well-targeted and effective public outreach and education to advise individuals about the new coverage options and the financial assistance available to those who qualify
- Well-functioning and easy application and enrollment in the Marketplace and in expanded Medicaid programs
- Adequate resources to ensure that individuals receive timely assistance with their questions relating to coverage, subsidies, and selection of a plan
- An appropriate number of affordable and attractive insurance options in the Marketplace
- Successful integration of Medicaid, Marketplace, and other health plan information systems for seamless eligibility decisions, enrollment, and subsidy administration
- Enrollment in the Marketplace of a balanced mix of health risks to create stable risk pools
- States’ decisions to implement the Medicaid expansion

Reforms as complex as ACA will undoubtedly encounter challenges in a diverse nation of 300 million. It will be necessary to monitor implementation and to identify and address trouble spots in order to adjust processes and policies that will ensure that the reforms function effectively.
Endnotes

1 Unless otherwise noted, analysis in this report is based on the U.S. Department of Commerce Census Bureau’s March 2013 Current Population Survey, and the terms “adults,” “older adults,” and “workers” refer to those ages 50 through 64.

2 These workers did not have coverage from their own employer or as a dependent on a family member’s employer health insurance.

3 The U.S. Treasury Department announced in July 2013 that shared responsibility payments will not apply until 2015 because they will not have the reports to determine which employers owe penalties for 2014.

4 Coverage is considered unaffordable if the employee’s share of the premiums for self-only coverage is more than 9.5 percent of his or her household income.

5 The penalty helps offset the cost of the public subsidies the employee receives.

6 Employers with no more than 100 employees will be eligible to buy through SHOP. The law allows states to limit SHOP to employers with no more than 50 employees until 2016. To date, most states have taken this route. States are permitted to open SHOP to larger employers in 2017.

7 State-based Marketplaces can choose to make this option available in 2014 or can defer to a later date. Federally facilitated Marketplaces have delayed this option until 2015.

8 If an employee’s share of the premium for self-only coverage is more than 9.5 percent of his or her household income.

9 This provision applies to employers with more than 200 full-time employees. The Department of Labor intends to issue regulations to implement this policy in 2014.

10 The law provides for exemptions from the penalty. See note 12.


12 This requirement will be monitored through the federal income tax form. All people who pay federal income taxes will have to show on their tax form that they had health insurance coverage the previous year and that it met the minimum standard, or they will face a tax penalty. Among the uninsured older adults in 2011, 2.1 million, or about one in five, did not file income taxes and, thus, would not be subject to a penalty if they remained uninsured in 2014. The grounds for exemption include having certain religious beliefs, experiencing a break in health coverage of fewer than three consecutive months during the year, having a lack of access to affordable coverage options, being a member of an Indian Tribe, experiencing hardship, or being a prisoner or an illegal immigrant.

13 In 2013, the federal poverty level is $11,490 for a one-person household and $23,550 for a family of four. The respective amounts for 400 percent of poverty are $45,960 and $94,200.


15 Eligibility for subsidies in the Health Insurance Marketplace is based on adjusted gross income. Variables in the U.S. Department of Commerce’s March 2013 Current Population Survey, on which this analysis is based, are not identical to the information that will be used to determine eligibility. However, the analysis provides an indication of the size or share of the population that potentially qualifies on the basis of those data. Analyses using different data sources and methods may vary from the numbers here.

16 Grandfathered plans—those that someone had as of March 23, 2010, when the law was passed—can be renewed even if they do not meet the new standards. Newer coverage is subject to the new standards, so insurers will have to phase out nongrandfathered plans.

17 ACA’s requirement that states expand Medicaid was made optional by the Supreme Court in National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012).
Effect of Health Reform for 50- to 64-Year-Olds


19 For example, eligibility for Medicaid under programs for the medically needy or aged and disabled.

